

## CASE HISTORY

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ Apt/ Unit/ Suite #: \_\_\_\_\_

City: \_\_\_\_\_ Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

E-Mail Address: \_\_\_\_\_

Date of Birth (D/M/Y) \_\_\_\_\_ Age: \_\_\_\_\_  Male  Female  Non-binary

Workplace: \_\_\_\_\_ Occupation: \_\_\_\_\_

Claim Will Be Made Against:

1. Recent motor vehicle accident  Yes  No (if yes, please let us know in advance or at reception)

2. Work related injury / accident  Yes  No (if yes please let us know in advance or at reception)

## HEALTH GOALS

**IT IS IMPORTANT** to us that we know what your health goals are. Please check off the statement that most closely reflects your health goals.

**SYMPTOM RELIEF:**

**CORRECTION OF THE PROBLEM:**

**OPTIMIZING HEALTH:**

**Chiropractic/Acupuncture:**

Have you had previous chiropractic/acupuncture?  Yes or  No

Where? \_\_\_\_\_

How long ago? \_\_\_\_\_ Why? \_\_\_\_\_

Were you satisfied with the results?  Yes or  No Explain: \_\_\_\_\_

**Medical Doctor:**

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ Date of Last Physical Exam: \_\_\_\_\_

**How did you learn about our office?**

Patient (Name): \_\_\_\_\_ Newspaper \_\_\_\_\_ Internet \_\_\_\_\_

Other health care provider (Name & Address): \_\_\_\_\_

Other: \_\_\_\_\_

## PERSONAL HEALTH HISTORY

Name: \_\_\_\_\_ DOB: (D/M/Y) \_\_\_\_\_

What is the reason for attending our office today? \_\_\_\_\_

**Are you currently or do you regularly suffer from the following symptoms:**

Heel pain	Ankle sprains/trauma	Arthritis: foot/ankle/knees/hips/back
Plantar fasciitis	Knee pain/trauma	Headaches
Metatarsalgia	Hip pain	Numbness in toes
Heel spurs	Back Pain	Circulatory disorders
Achilles tendonitis	Neck Pain	Pins and needles in toes
Bunions	Diabetes	Claw toes
Forefoot pain	Hammer toes	Corns
Calluses	Flat feet	High arches
Shin splints	Patellofemoral syndrome	Iliotibial band syndrome

**Medications you now take:**     Anti-inflammatory     Pain Killers     Muscle Relaxants

Blood Pressure     Tranquilizers     Insulin     Birth Control Pills

Other: \_\_\_\_\_

List all surgical operations and years: \_\_\_\_\_

Have you had any spinal x-rays taken in the last 2 years?     Yes     No

Where were they taken? \_\_\_\_\_

**Family Health History**

Please check off any conditions listed below that your immediate family members (Parents/Siblings/ Grandparents) have or have had and note their relationship (e.g. Mother, Father Brother) in the space provided

Condition	Check if Applicable	Relation
Chronic Back or Neck Pain	<input type="checkbox"/>	
Scoliosis/ Spinal Deformity	<input type="checkbox"/>	
Disc Problems (herniated/ bulging)	<input type="checkbox"/>	
Osteoarthritis	<input type="checkbox"/>	
Rheumatoid Arthritis	<input type="checkbox"/>	
Stroke/ High Blood Pressure	<input type="checkbox"/>	
Diabetes	<input type="checkbox"/>	
Cancer	<input type="checkbox"/>	
Other Major Health Condition (specify)	<input type="checkbox"/>	

Name: \_\_\_\_\_ DOB: (D/M/Y) \_\_\_\_\_

Your height: \_\_\_\_\_ Your weight: \_\_\_\_\_

Approximate shoe size (most commonly worn) \_\_\_\_\_ M or W

Do you currently wear:  heel lifts  orthotics  arch supports  
If yes, to orthotics, how old are the orthotics? \_\_\_\_\_ How many pairs do you have?  
\_\_\_\_\_ Where were they made? \_\_\_\_\_

If you are not currently wearing orthotics, have you worn orthotics in the past? Y N

Please select what type of footwear that you wear approximately 80% of the time or greater.

Casual shoes	Loafers	Running shoes	Walking shoes
Work boots	Dress shoes	Heels	Sandals

## LIFESTYLE HISTORY

**YES NO**

- Are you a non-smoker?
- Do you drink 8 glasses of water per day?
- Do you drink fewer than 2 caffeinated beverages per day?
- Do you exercise regularly?  Up to 3 hours/wk  3-6 hrs/wk  over 6 hrs/wk
- Do you feel you have a healthy diet? (low fat, high fiber, raw foods)
- Do you drink one or less alcoholic beverage per day?
- Do you sleep well (6-9 hours uninterrupted)?

Age of mattress: \_\_\_\_\_ What is your sleeping posture?  Side  Stomach  Back

Are you under stress at:  Work  Home or  School

Do you take any vitamins, herbs or other supplements?  Yes  No

Please list: \_\_\_\_\_

What is your job description? \_\_\_\_\_

What is your work schedule? \_\_\_\_\_

What are your hobbies? \_\_\_\_\_

**Please note we have a 24-hour cancellation policy.**

We value your time and we appreciate when you value ours as well as the time of other members of our practice. Appointments cancelled with less than 24 hours of notice will be charged the fee equivalent to the missed or cancelled appointment. We do realize that life happens sometimes and for extenuating circumstance, such as illness, and medical emergencies, we will make an exception.

**Please initial to indicate that you have read and understand this policy.** \_\_\_\_\_